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RESPONSIBILITIES OF HOSPITALS TODAY AND TOMORROW*

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Hospitals originated as places for the care of the feeble and infirm. Over the centuries, with the advance of medical science, they have developed into modern "general hospitals." Recently they have become known as "acute general hospitals." More properly perhaps these institutions should now be called "acute hospitals" inasmuch as they have almost lost through neglect their function as places for the general care of the sick. Instead they have become converted into places for childbirth and for the diagnosis of illness and treatment of its acute phases—the so-called "doctor's workshop."

LEADERSHIP IN THE REINTEGRATION OF HOSPITAL SERVICES

Meanwhile society has developed a wide array of other institutions for the care of the sick. Mental hospitals, mostly under state governmental auspices, now provide about half of all beds for the care of the sick. The tuberculosis sanitarium represents another type of institution for a special type of illness. Patients with chronic illness have been shunted off into custodial facilities known under various labels. This fragmentation of institutional services for the care of the sick arose largely on the basis of expediency. Certainly the present arrangement is no rational plan.

The time is now arriving for a reintegration of all institutional services to the sick, for the development of a truly general hospital. This will be a place for the patient irrespective of whether his disease is of the body or the mind. (Incidentally, we are becoming less sure of such distinctions as we find that certain diseases such as asthma and hypertension appear to have a large emotional component; and other, so-called mental diseases may result from metabolic disturbances.) The general hospital will be a place for the seriously ill person no matter what germ or virus causes his disease. Modern understanding and techniques of communicable disease control in the hospital make unnecessary the operation of separate facilities for patients with infectious diseases.

Likewise of real importance is the opportunity to develop in a general hospital the services which are proving so effective in the rehabilitation of persons with chronic illness. Patients with what physicians term "acute, self-limited disease" have for many years obtained excellent care in general hospitals. On the other hand patients with chronic disease, for example, those with residual damage to the brain following cerebral hemorrhage—these patients have not fared so well in the past. Only recently have they been receiving the kind of intensive therapy often needed for a lengthy period after the acute phase of illness. This long-term care frequently helps the individual patient to achieve a much higher degree of recovery than was considered possible during the years when neglect was the order of the day for chronic illness. Nowadays, an increasing number of general hospitals are turning their efforts toward intensive care of the chronically ill. The Veterans Administration hospitals and some county hospitals in California are doing outstanding jobs in this respect. Some nongovernmental hospitals, too, are developing services of this type.

GENERAL IN FACT AS WELL AS NAME

If hospitals are to become truly general hospitals, it seems appropriate for them to develop services for mental illness, tuberculosis and other types of chronic illness—in fact all conditions for which people need care

*Based on a presentation at San Francisco Hospital Conference, November 8, 1957.

WORLD HEALTH DAY—APRIL 7

outside their own homes. This means of course a substantial change in the character of the hospital—in our concept of the hospital, in its operations, its relationship to nursing homes and other facilities, and probably in its economics. If hospital leaders are going to be limited in their thinking and planning by such attitudes as "We can't handle drunks," "Mental patients disrupt the rest of the hospital operations—keep them out," and "Our budgets won't stand for services to chronically ill patients who have no resources"—if these purely negative attitudes prevail among hospital administrators, and boards of trustees, then the community will seek other means of dealing with these pressing problems in the care of the sick. All of us in the health field, whether it be hospital administration or public health or the practice of medicine, must realize from repeated historical experience that in a democracy the people ultimately find a way to solve urgent social problems such as how to care for the sick.

The question today is the responsibility of hospitals. Obviously one responsibility is to assume leadership of the growing public concern with the need for improving the institutional care of the sick, all the sick who require such care. Who is better suited to tackle this problem than hospital administrators and members of their boards of trustees? What more important policy faces present-day hospital leaders than reversing the long-time trend toward fragmentation of hospital services and starting on the path toward integration of services for the sick in a general hospital? This is a prime responsibility and one that entails broad consideration of the current relationship of hospitals to all the other institutions caring for the sick.

DEVELOPMENT OF NEW COMMUNITY HEALTH SERVICES

Besides reintegration of institutional services for the sick into the general hospital, another aspect of hospital responsibility pertains to the development of new community health services, including organized home care and preventive services.

Organized Home Care

It is now clear that home care offers a desirable way of providing certain services, particularly for the chronically ill. Principles of home care are now emerging from nationwide discussion of the issues, for example, in such documents as *Care of the Long-Term Patient.** However, the major administrative question remains unsettled—how and by whom is home care to be organized? A strong case for hospital leadership and administration arises from consideration of some of the important principles of home care. The latter include (1) provision of a wide array of health services such as laboratory service, physical therapy and others which are usually found most highly developed in hospitals; (2) assurance to the patient and family of immediate admission to a hospital should the need arise; (3) high quality medical direction of the program, such as the medical staff of a hospital might ensure; and (4) continuity of care between the home and hospital. All of these features of home care would seem best assured through hospital administration. This, of course, is not to say that hospitals should ignore other available community resources such as health departments, visiting nurse associations and other health and welfare agencies. Co-ordination is needed. The question again is one of leadership—who is going to assume it?

Preventive Services

Another community health service which is receiving increasing attention nowadays is prevention, especially what has become known as secondary prevention of chronic illness. The public appears to be grasping at least as rapidly as the health professions the idea that a tremendous amount of disability and premature death from chronic illness can be avoided. Discovering disease early and treating it properly will accomplish this purpose. Most familiar is the example of tuberculosis. But other diseases, too—diabetes, certain forms of cancer, glaucoma and many more—present a far better prognosis if they are detected in their early stages and properly treated, than if the patient delays until the full-blown clinical picture appears. Hospitals have played a substantial role in tuberculosis case-finding during recent years, and many hospitals include urinalysis for sugar and other laboratory screening procedures as a part of their administrative routine. However, they have not developed this aspect of service into a conscious effort to advance the secondary prevention of chronic illness through case-finding. A moment's reflection on the number and character of persons who receive inpatient or outpatient care at hospitals during a year will indicate the potentiality for preventing chronic illness by the systematic use of screening tests.

* Report of the Commission on Chronic Illness, Volume II, Harvard University Press, 1957.

HOSPITAL COSTS AND CHARGES

Any serious discussion of hospital responsibility today and tomorrow would be lacking in candor if it failed to consider the matter of costs and charges. Perhaps no aspect of health service including hospital care bothers the public so much as the cost, and our failure as yet to develop satisfactory means of handling it. Hospitals may have done as well or better in this respect than other elements of our health service. But "better than" is not necessarily "good enough." As organized consumer interest presses the inquiry into where the health insurance dollar goes—and this consumer interest is rapidly becoming more sophisticated—better answers must be found than are now given.

Those who pay the bill have a right to know whether any of their dollar is being wasted. They want to know, for example, why it is necessary to pay for the bed care in the hospital when outpatient or physician's office services would often do the diagnostic job as well, and at far less cost. This is one of the most obvious abuses of the hospital insurance dollar which hospitals must undertake to correct if they are to secure the advantages to themselves of the present forms of health insurance.

The public looks first of all to hospitals to assume responsibility for dealing with such problems.

One hears rumblings of protest, too, against the practice by a small minority of hospitals of basing their charges too much on the extent of insurance money available, e.g. for laboratory and X-ray service, rather than upon the amount of service needed for the case. Even though only a few hospitals are involved in such

practices the outcry goes up against hospitals as a whole, and thus all hospitals share somewhat the ill will engendered.

QUALITY OF CARE

Besides examining more rigorously the problem of costs, the public also appears to be turning a more critical eye to the matter of quality of medical care, including that provided in hospitals. Those of us in medicine and in hospital administration have long expressed pride in such safeguards to the quality of care as are provided by the autopsy, the clinico-pathological conference and other devices.

However, new methods for the evaluation of the quality of care are being developed at the present time. Some of these depend upon quite simple statistical studies, for example, the comparative rate of appendectomies and hysterectomies in various hospitals, in relation to the mortality and morbidity from conditions of the appendix and uterus. While it is difficult to assess culpability in any individual case, persistently high rates of certain surgical procedures in the absence of special circumstances indicate situations requiring attention. Another illustration of a simple test on the quality of care is the percentage of cases diagnosed as cancer in which the hospital record includes a histopathological report.

Many such inexpensive record checks and other procedures may be devised to examine the quality of care in the hospital. Numerous resources are now available in California to assist evaluation schemes of this sort. Again hospitals ought to take the lead in developing such studies.

PROFESSIONAL EDUCATION

Although hospitals have prided themselves on being instruments for education of physicians and other professional health personnel, several changes during the recent past have tended to narrow the role of hospitals in professional education. One of the most obvious is the increasing professionalization of nursing and the shift of much nurses training previously done by hospitals into universities and colleges.

In respect to physicians the current trend toward hospital practice largely by specialists has isolated many general physicians from the hospital, particularly in metropolitan areas of the eastern United States, e.g. Baltimore, Maryland. On the other hand certain specialists work at several hospitals and cannot possibly take part in all of the educational program at any one hospital. Hospitals and their medical staffs face a crisis in respect to physician education, a crisis which appears to be developing quite rapidly. They may disavow any responsibility for education of physicians not on their staffs, but to do so may aggravate the all-too-evident trend toward two standards of medical practice in the community. This would ultimately deprive the hospital staff of close contact with nonhospital physicians who see many patients before and after hospitalization. In the long run this trend may well boomerang against the hospital and its medical staff.

American hospitals might consider following the pattern established by the Central Middlesex Hospital of London, a professional education program for *all* physicians of the community irrespective of whether they are on the hospital staff. Such a program would tend to minimize the schism between hospital-affiliated physicians and physicians not affiliated with hospitals, a schism which augurs no good for patients, physicians or hospitals.

PUBLIC HEALTH EDUCATION

Besides professional education, hospitals also have an excellent opportunity for health education of the public. The time when a member of the family is ill offers the ideal moment—from the standpoint of motivation—for such education. Yet this opportunity is almost entirely neglected. Hospitals could easily call upon the public health department, insurance companies and other sources of health education materials and service for aid in this endeavor. The cost to the hospitals themselves would be negligible and the little effort would no doubt be much appreciated by patients and their families. Also, a well-organized health education program could serve a highly practical purpose to the hospital itself: it would make easier the job of personnel who must now individually explain many things to patients and relatives. Among other advantages, this would probably result in fewer readmissions for certain chronic conditions such as repeated cardiac decomposition.

CO-ORDINATION

A final responsibility, and perhaps the most important one for hospitals, is that of co-ordination in the expansion of hospital facilities and services to meet public needs, as recommended by the Commission on Hospital Care. Gaps in co-ordination among the hospitals of many local communities, the State, and Federal Government continue to exist. In some instances the discordance seems to become even more glaring. If hospital administrators would remove themselves momentarily from the day-to-day activities in which they are enmeshed and look upon the situation from afar, they would perhaps see a picture resembling a crazy quilt. All of us profess belief in a single high standard of care, irrespective of the condition for which care is sought or the social status of the individual patient. To what extent is the present arrangement of hospital service consistent with these ideals? The Federal, State and local governments, of course, share heavily in the responsibility for the present lack of co-ordination. The time has certainly arrived to seek intensively a rational plan for hospital services. It would of course be illusory for anyone to consider that this will be easy. The situation involves long-established practices by Federal, State and local government and by proprietary institutions such as nursing homes, as well as a pattern of individual voluntary hospital effort.

However, hospital leaders will not much longer be able to avoid responsibility for making the effort to evolve a rational and comprehensive plan for hospital services in the interest both of better service to patients and economy.

SUMMARY

These, then, are some of the major challenges confronting hospitals today: leadership in the reintegration of hospital services; development of new community health services; organized home care and preventive services; hospital costs and charges; quality of care; professional education; public health education; and co-ordination of services.

TEN YEARS OF HEALTH PROGRESS

DR. M. G. CANDAU
Director-General of the World Health Organization

World Health Day this year is also the tenth anniversary of the day when the Constitution of the World Health Organization came into force. It therefore seems a good opportunity for all of us to review the progress towards better health made during the last decade in each country and throughout the world.

There have been great scientific advances—new drugs, new vaccines, new or improved insecticides and better methods of combatting and preventing disease.

This new knowledge is being rapidly applied where it is needed. In the last 10 years the flow and exchange of scientific information and practical experience have perhaps been greater than ever before. More scientists and health workers than ever before have gone from country to country to learn, to teach and to demonstrate.

Even more important is that an increasing number of people everywhere realize that health is a way of living and thinking, and not merely the absence of disease and infirmity. Governments have come to accept their responsibilty for the health of their peoples, and their obligation to provide, besides the classical hospitals and institutions, improved environmental conditions, health care for mothers and children, and safeguards for food and nutrition.

In all this there is nothing very new. For a hundred years or more, advances in the science of healing have been shared freely by all countries, health pioneers have been urging the importance of sanitation, and governments have slowly brought in health legislation and built up health services. The last 10 years are remarkable, then, for a general speeding up and extension of health progress along established lines.

But this is not all. Underlying the accelerated progress has been a profound change in thinking and in method.

At an international health conference held in New York in 1946, 61 governments asserted that low health standards anywhere in the world are a common danger, and that health is consequently a world concern and not simply a national concern. Health, like peace, is one and indivisible. They laid down new principles for international health co-operation and embodied them in the Constitution of the World Health Organization, which came into force two years later.

The nations that banded themselves together 12 years ago to set up this world co-operative for health with a program far out-reaching anything previously attempted have since been joined by 27 others, bringing WHO's membership to 88.

Their action has already brought a number of benefits to all. Rapid pooling of information and experience makes it simpler to contend with diseases like influenza and poliomyelitis, to meet the threat to mental health that grows from modern conditions of life, to adapt medical education to changing needs, and to study emerging problems like that of the hereditary effects of radiations.

Those countries that are struggling to conquer age-old diseases and to build up modern public health services benefit further from the practical help given, in the true "co-operative" spirit, by all countries through the World Health Organization. Ten years of trial and error, of success and failure, have shown the usefulness and also the limitations of this international assistance. As their confidence grew in the possibilities thus offered for hastening progress, health administrations have also learned what efforts they themselves must make in order to obtain the best results from outside help.

From all this one fact emerges clearly—what, 10 years ago, was little more than fine words on paper has now become a living reality. What was a vision seen only by a few far-sighted men has, with all its imperfections, become a trusted instrument in the service of all countries. And this, I venture to think, will be considered by future historians as one of the most significant factors in health progress in this 10-year period.

Influenza Deaths Decline Slightly As Do Lab Confirmed Cases

Influenza and pneumonia deaths as recorded in eight selected cities of California declined to 36 in the week ending March 1st, as compared to 50 for the previous week. This is the lowest number of deaths recorded since the week ending Deceember 28, 1957.

Deaths in February of this year were at a slightly higher level than they were in January, and were considerably higher than in February, 1957. Weekly figures from the eight cities for the month of January were: 40, 40, 46 and 49. For February they were: 37, 57, 43 and 50.

These deaths have been principally among the elderly and those suffering from severe chronic disease. California's pattern of deaths associated with influenza and pneumonia has closely paralleled that seen throughout the Nation.

Laboratory evidence now indicates that less than one-fourth of the cases of respiratory illness in California are presently due to influenza. During the first week in March the percent of blood specimens positive for influenza dropped to 23, as compared to 29 percent for the previous week. This is the lowest percent of influenza positive "bloods" to be reported for any week since the week ending August 30, 1957.

Information gathered by the California Health Survey showed the amount of respiratory illness to be about the same in February as in January. In both months there were approximately one million new cases a week. About 30 percent of the total cases of respiratory illness required one or more days in bed.

CTHA Meets in San Mateo

The 1958 annual meeting of the California Tuberculosis and Health Association will be held at the Villa Hotel in San Mateo, April 10th-12th.

Two major target areas will be under consideration at the meeting: "Our Common Problem—Alcoholism" and "Radiation and Research."

The annual Trudeau and Higby awards and the California Medal to the year's outstanding medical man will be presented during the meeting.

Polio Disease Season Under Way, Two Million Still Unprotected

The task of vaccinating Californians under the age of 40 against the crippling effects of polio is little more than half completed after more than two years of intensive efforts by health departments and private physicians. The current polio disease year begins this month with more than 2 million Californias under the age of 40 who still have not yet received their first Salk vaccination. Eight months are required to complete the recommended series of three inoculations. The polio season will probably reach its peak in September.

The age groups requiring special effort are preschoolers under the age of five and young adults, in whom most of the paralytic cases and all of the polio deaths have occurred. It is in these age groups that most of the unvaccinated are found.

It is estimated that about 14 million polio shots have been given, with approximately 12 million more shots needed to provide full protection against paralytic polio to the estimated 8,698,560 Californians under the age of 40.

Of the 14 million shots already given, 6,500,000 were first shots, 5,250,000 were seconds, but only 2,380,000 were third shots. This means that 72 percent of the susceptible population have not received their booster shots —completed the recommended series of three shots for maximum protection against paralysis.

Since the supply of public-purchased vaccine is about exhausted, the unvaccinated and partially vaccinated must seek protection through private physicians or through group immunization plans. It is possible that local health departments in some areas will incorporate polio vaccination in their regular immunization programs.

The effectiveness of the vaccine against paralysis is pointed up by the fact that of the 255 cases of paralytic polio reported since last April, 176 were in the unvaccinated population. Of that number, 140 were in preschool youngsters and in young adults. The majority of vaccinated cases of paralytic polio were in persons who had only one or two of the recommended three shots.

There have been 14 deaths since April 1, 1957, all in unvaccinated persons. Twelve were young adults and two were children under the age of five.

Each year California's population is increased by some 345,000 births. These children must be protected. On top of this are the approximately 350,000 persons who move into the State yearly, many of them unvaccinated. If strenuous efforts to continue and to increase the vaccination rates are not made, it will not be long before another million or two are added to the large segment of the population as yet unprotected against paralytic poliomyelitis.

Statewide Crop Damage Survey in Third Year

Crop damage is one of the most sensitive indicators of air pollution, and can generally be relied upon to indicate the presence of air pollution before it reaches the stage that causes irritation to the general population.

For the past two years the Agricultural Extension Service has been conducting a statewide air pollution plant damage survey to determine: the areas affected by polluted atmospheres and to what extent; the frequency of occurrence and the seasons when air pollution is a problem; how extensively agricultural crops are damaged; and the type of pollutants as shown by plant symptoms. The California State Department of Public Health is working with the Extension Service in the co-ordination of data.

In 1956 over 1,600 observations were reported of which 36.9 percent recorded plant damage. In 1957 there were over 4,000 observations reported with 50.8 percent indicating damage from air pollution.

Counties which have recorded plant damage are: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Madera, Marin, Merced, Napa, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, San Joaquin, Santa Clara, Solano, Sonoma, Stanislaus, Tulare and Ventura.

Toxic Alcohol Addicts Have Common Characteristic

That many an alcoholic will turn in desperation to Sterno, bay rum, rubbing alcohol, vanilla extract or some other poisonous intoxicating substance is a well documented fact. A recent study indicates that some alcoholics actually prefer to drink these toxic alcohols. The study also shows that these persons have definite personality traits in common.

A striking degree of submissiveness and compliance seems to be the common characteristic of these persons addicted to toxic alcohols, according to study findings of Menoelson, Wexler, Leiderman and Solomon, reported in the *Journal of Studies on Alcohol.* The persons seem to be utterly devoid of overt hostility and aggression, the report continues; however, all revealed strong feelings of unconscious guilt, self-debasement and need for punishment.

The personality of these persons is the underlying reason they turned to toxic alcohol, the report concludes.

SPECIAL CENSUS RELEASES *

Special Census of California cities, **Series P-28** *Contra Costa County:* Concord (1088), *Los Angeles County:* Bell (1039), El Monte (1087), Gardena (1054), Manhattan Beach (1049), Montebello (1053), South Pasadena (1067); *Merced County:* Merced City (1048); *Orange County:* Fullerton (1084), Orange (1079); *San Bernardino County:* Rialto (1042); *San Diego County:* El Cajon (1083).

Copies of these releases may be obtained from: Library, Bureau of Foreign and Domestic Commerce, United States Department of Commerce at 419 Customs Building, 555 Battery Street, San Francisco, California, or at Room 450, 1031 South Broadway, Los Angeles, California.

* In ordering, specify series and number as shown in parenthesis. These numbers are *not* population figures.

Improvement in Smog Control Noted

Los Angeles County's intensive air pollution control program may be paying dividends, at least for downtown Los Angeles, according to data on air measurements that have been made in that area. However, air pollution continues to be a serious problem in the Los Angeles area. The frequent episodes of eye irritation which occurred during the past year point up the problem.

Comparison of data collected in 1956 and 1957 show that there was also some improvement in San Diego County and the San Francisco Bay area, although it was not as marked as in Los Angeles.

On the other side of the coin, the rapidly growing areas near Los Angeles, such as Riverside County, showed no decrease in air pollution and there are indications that the Central Valley is experiencing some air pollution.

Last year the Los Angeles County Air Pollution Control Board found it necessary to call only one smog alert. Sixteen alerts were called in 1955, when the alert system was begun, and 10 in 1956. According to studies made by the district, crop damage and eye irritation were lower in 1957 than in 1956 and visibility improved.

Oxidant levels in the San Francisco Bay area and in San Diego County were lower in 1957 than in previous years and there was a decrease in the number of elevated readings. Oxidant level is one index of air pollution.

Since San Diego does not have a control program and San Francisco is only beginning theirs, it is evident that the improvement in these two areas was not due to a reduction in the pollutants being discharged into the atmosphere.

Subtle changes in weather conditions, as well as other still unknown factors, undoubedly contributed to the slight improvement seen last year.

The California State Department of Public Health will continue its air measurement and data evaluation program in an effort to determine trends in air pollution in the State.

Mice are most active between 8 and 9 p.m.—*World Health, Jan.-Feb., 1958*

Death Ends Career of H. Seymour Jones

H. Seymour Jones, Senior Food and Drug Inspector in the Bureau of Food and Drug Inspections, California State Department of Public Health, died recently in San Pedro after a long illness.

Mr. Jones joined the department in June, 1931, when Dr. Giles Porter was director. He was one of the original members of the Bureau of Food and Drug Inspections and was instrumental in the development of the field activities of the bureau.

He was appointed Senior Food and Drug Inspector in 1947 and served in this capacity in various sections of Southern California, particularly Orange, Ventura and Santa Barbara Counties.

Mr. Jones was held in the highest esteem by his fellow employees, and also earned the respect of the State's food manufacturing industry.

He was well known, too, for his avocation, amateur radio broadcasting. He had one of the earliest "ham" stations, W6AX. During the war years in the late evening and early morning hours he sent and received many messages for servicemen. He was one of the few amateur operators who were able to communicate with the Admiral Byrd Expedition at the South Pole. He gave much of his spare time to radio work on the Los Angeles County Sheriff's Disaster Committee.

Mr. Jones was born in Chicago in 1904 and received his formal education at the University of California and the University of Redlands.

He is survived by his widow, Bess Porter Jones; a daughter, Mrs. Gene Prickett, and three grandchildren; his mother, Louise Seymour Jones, and a brother, Rex Jones.

SPECIAL CENSUS RELEASES

Estimates of the Farm Population of the United States, April, 1950 to 1957. *Farm Population,* October 20, 1957, **Series P-27,** (24).

Provisional Estimates of the Population of States and Selected Outlying Areas of the United States, July 1, 1957. *Current Population Reports, Population Estimates,* December 9, 1957, **Series P-25,** (168).

Estimates of the Population of the United States, by Age, Color and Sex, July 1, 1955 to 1957. *Current Population Reports, Population Estimates,* December 18, 1957, **Series P-25,** (170).

School Enrollment Reaches 41.2 Million. *Current Population Reports, Population Characteristics,* December 30, 1957, **Series P-20,** (78).

Educational Attainment: March, 1957. *Current Population Reports, Population Characteristics,* December 27, 1957, **Series P-20,** (77).

Provisional Estimates of the Population of the United States, January 1, 1950 to December 1, 1957. *Current Population Reports, Population Estimates,* January 15, 1958, **Series P-25,** (171).

Estimates of the Civilian Population by Broad Age Groups, for States, Hawaii and Puerto Rico: July 1, 1956. *Current Population Reports, Population Estimates,* January 20, 1958, **Series P-25,** (172).

Religion Reported by the Civilian Population of the United States: March, 1957. *Current Population Reports, Population Characteristics,* February 2, 1958, **Series P-20,** (70).

Copies of these releases may be obtained from: Library, Bureau of Foreign and Domestic Commerce, United States Department of Commerce at 419 Customs Building, 555 Battery Street, San Francisco, California, or at Room 450, 1031 South Broadway, Los Angeles, California.

In ordering, specify series and number as shown in parenthesis. These numbers are *not* population figures.

Simple Test Holds Promise In Detecting Phenylketonuria

Mental deterioration due to phenylketonuria, a disorder of infants in which there is an inability to metabolize the essential amino acid phenylalanine, present in all proteins, is preventable if diagnosis is made early and the child is placed on a low-phenylalanine diet. This disease, which develops within six weeks after birth, accounts for about 1 percent of the mentally deficient persons in California institutions.

A simple diaper test is now available, which if proven reliable, will provide an inexpensive screening test to detect phenylketonuria early in infancy. A program is now under way in the well baby clinics of Southern California to determine the effectiveness of the test.

The test consists of placing a drop of 10 percent aqueous ferric chloride on an infant's wet diaper. The appearance of a dark-green color indicates that the baby may have phenylketonuria. Since it is possible to get false positives or negatives with the test, infants are being checked for a one-year period at each well baby clinic visit. As far as is known this is the first large-scale attempt in this Country to screen well babies for this disease. The program has been under way since July 1, 1957. It will be another year or two before an evaluation of the method can be made.

At the present time, the following health departments are using the test in their well baby clinics: Los Angeles City, Los Angeles County, San Bernardino County, San Diego County, and the City of Ontario.

Cleft Lip Treatment Symposium

A statewide symposium to demonstrate the merits of group management in treating cleft lip and palate patients is scheduled for April 21-22 at Saint Francis Memorial Hospital in San Francisco. The meeting is sponsored by the Plastic and Reconstructive Surgery Center of the hospital and is open to all who are interested in corrective methods for this type of deformity.

Featured speakers will be four nationally known experts from the University of Illinois. They are: Herbert R. Kobes, M.D.; Herbert Hoepp-Baker, Ph.D.; Edward F. Lis, M.D.; and Samuel Pruzansky, D.D.S.

Program details may be obtained by writing Saint Francis Memorial Hospital, 900 Hyde Street, San Francisco.

REPORTED CASES OF SELECTED NOTIFIABLE DISEASES CALIFORNIA, MONTH OF FEBRUARY, 1958

Disease	Cases reported this month			Total cases reported to date		
	1958	1957	1956	1958	1957	1956
Amebiasis	161	180	50	341	280	114
Anthrax	--	--	--	--	--	--
Botulism	--	--	--	--	--	--
Brucellosis	2	2	2	7	2	6
Chancroid	11	6	6	13	17	17
Cholera	--	--	--	--	--	--
Coccidioidomycosis	13	10	6	30	28	28
Conjunctivitis, acute infectious of the newborn	3	1	1	6	1	1
Dengue	--	--	--	--	--	--
Diarrhea of the newborn	11	--	1	14	8	2
Diphtheria	--	1	2	1	4	12
Encephalitis, acute	29	23	26	64	49	67
Epilepsy	241	258	279	504	613	628
Food poisoning	72	21	6	242	75	103
Gonococcal infections	1,087	1,336	1,142	3,083	2,929	2,610
Granuloma inguinale	--	1	--	--	2	--
Hepatitis, infectious	150	143	158	339	349	399
Hepatitis, serum	6	7	6	20	16	12
Leprosy	1	2	1	1	5	1
Leptospirosis	1	--	1	2	--	1
Lymphogranuloma venereum	3	1	3	7	6	5
Malaria	1	--	3	2	2	4
Measles	2,722	8,577	2,517	4,375	13,900	4,957
Meningococcal infections	26	17	27	43	38	65
Mumps	2,022	2,263	4,412	3,905	4,421	9,590
Pertussis (Whooping cough)	275	101	174	532	246	367
Plague	--	--	--	--	--	--
Poliomyelitis—						
Total	11	23	94	28	69	259
Paralytic	9	14	66	18	42	180
Nonparalytic	2	9	28	10	27	79
Psittacosis	--	3	2	3	3	6
Q fever	--	--	2	--	--	4
Rabies, animal	4	5	22	17	9	60
Rabies, human	--	--	--	--	--	--
Relapsing fever	--	--	--	--	--	--
Rheumatic fever	17	14	12	30	28	29
Rocky Mountain spotted fever	--	--	--	--	--	--
Salmonellosis	31	49	91	104	108	175
Shigellosis	86	106	139	240	178	314
Smallpox	--	--	--	--	--	--
Streptococcal infections (including scarlet fever)	1,080	1,078	621	2,178	2,150	1,249
Syphilis	449[a]	469	530	1,061[b]	981	985
Tetanus	2	2	4	5	5	6
Trachoma	--	--	--	1	--	2
Trichinosis	--	--	1	--	--	1
Tuberculosis	507	640	494	1,156	1,230	1,092
Tularemia	1	--	--	1	--	1
Typhoid fever	8	3	4	12	9	14
Typhus fever, endemic	1	--	2	1	1	2
Typhus fever, epidemic	--	--	--	--	--	--
Yellow fever	--	--	--	--	--	--

[a] Excludes 241 cases found positive by special serologic survey (Mexican national farm workers at Border Reception Center, El Centro).

[b] Excludes 440 cases found positive by special serologic survey (Mexican national farm workers at Border Reception Center, El Centro).

Attorney General's Opinions

Preventive Inoculation of School Personnel. In the opinion of the Attorney General a health officer may give teachers, employees and pupils preventive inoculations against contagious diseases, such as Asian flu, if the health officer determines that inoculations are necessary to prevent the spread of the disease. The cost of these inoculations, when approved by the school board, is a proper charge against school district funds.

The opinion was based on Section 16444 of the Education Code which provides that: "* * * the governing board of any school district shall cooperate with the local health officer in measures necessary for the prevention and control of communicable diseases in school age children. For that purpose the board may use any funds, property, and personnel of the district. * * *"

"Kosher Style" Dill Pickles. In a recent opinion the Attorney General held that food processors do not violate Section 383b of the Penal Code if they pack dill pickles and label them "kosher style," although they are not prepared and packed in such a manner as to render them strictly kosher according to orthodox Jewish ritual requirements.

The Attorney General in his opinion emphasized that the opinion deals only with dill pickles packed and labeled as "kosher style" and does not purport to apply to other products or establishments so designated.

Public Health Positions

Los Angeles City

Senior Public Health Microbiologist: Salary range, $464-$575. Requires three years of experience as a microbiologist and a valid California certificate.

Public Health Microbiologist: Salary range, $395-$489. Candidates must have or be eligible for California certification.

Applications, $1 filing fee required, will be accepted in Room 5, City Hall, Los Angeles 12, until further notice.

Placer County

Sanitarian: Salary range, $358-$435, starting salary dependent on experience. For details write Richard White, M.D., Health Officer, Placer County, 360 Elm Street, Auburn.

San Mateo County

Director, Public Health Nursing Service: Salary range, $581-$725. Position requires Master's degree in Public Health Nursing and five years' public health nursing experience, two years of which have been in a supervising capacity in a public agency. Contact San Mateo County Civil Service Commission, Courthouse, Redwood City.

Sheriffs Now Better Equipped To Deliver Babies

Deputy sheriffs in Los Angeles County are now receiving instruction in midwifery as a regular part of their training before being assigned to duty. The Los Angeles County Sheriff's Department receives an average of 52 calls a month to transport expectant mothers to hospitals and many a deputy has found it necessary to make the delivery en route.

Under the plan developed by the department, each new group of recruits attends a four-hour class on emergency childbirth to familiarize them with procedures that can be carried out safely by a medically untrained person with no sterile equipment at hand. A physician and a public health nurse from the county health department demonstrate what should, as well as what should not, be done in such emergencies. Each man is given written basic instructions at the end of the course.

In addition to the recruits in training, occasional classes are arranged for regular officers and for volunteer reserve officers.

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